Cover Sheet / Written Testimony

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Attribute statement to: American Federation of Labor and Congress of Industrial Organizations (AFL-CIO)

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Statement

American Federation of Labor and Congress of Industrial Organizations

Subcommittee on Health of the House Ways and Means Committee

Examining Traditional Medicare's Benefit Design

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We thank Chairman Brady, Ranking Member McDermott, and the members of the committee for the opportunity to submit this statement for the hearing titled, "Examining Traditional Medicare's Benefit Design." The American Federation of Labor and Congress of Industrial Organizations (AFL-CIO) is the nation's largest labor federation, representing more than 12.2 million workers, and we believe that it is important to discuss the adequacy of Medicare's benefit design.

Medicare plays a crucial role in preserving the middle class and lifting working families out of poverty. Before it was enacted in 1965, about half of all older adults did not have hospital insurance[1] and close to three-in-10 lived in poverty.[2] Now, health coverage for seniors is almost universal, and Medicare's support for their financial security has combined with improvements in Social Security benefits to decrease the poverty rate for seniors to 8.7 percent in 2011.[3]

Nonetheless, Medicare's benefit design does not meet all of beneficiaries' needs, as evidenced by the fact that most beneficiaries turn to supplemental coverage to fill in the program's significant coverage gaps and to protect themselves better against unpredictable out-of-pocket costs. Medicare generally covers only about 60 percent of health services costs for seniors, and a retired couple with median prescription drug needs would require $227,000 in savings to be fairly certain of covering just their health costs in retirement.[4] The lack of an out-of-pocket maximum and the as-of-yet-unfilled "donut hole" in prescription drug coverage represent two major gaps that create significant financial risk for beneficiaries.

We are concerned, however, that changes to Medicare's cost-sharing structure could be used as a guise to achieve deficit reduction by shifting costs to beneficiaries, not to improve benefits for older adults. We urge members to reject this approach and instead focus on ensuring that Medicare provides adequate coverage for seniors and people with disabilities.

Cost-Shifting to Beneficiaries to Reduce the Deficit

Some economists assert that Medicare beneficiaries are "overinsured," causing them to use more services than are needed. These economists have proposed that beneficiaries pay additional out-of-pocket costs each time they use a service, giving them more "skin in the game." A number of recent proposals would redesign Medicare's benefit structure to build in these extra charges. This is seen as

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[1] Health Care Financing Administration, *Medicare: A Profile*, p. 33 (July 2000).
[2] Census Bureau, http://www.census.gov/hhes/www/poverty/data/historical/people.html (downloaded 2/25/13).
[3] Id.
[4] Fronstin, P. Savings needed for health expenses for people eligible for Medicare. Employee Benefit Research Institute Notes. (October 2012) http://www.ebri.org/publications/notes/index.cfm?fa=notesDisp&content_id=5121

one way to address the incentives for providers to supply too much care in a fee-for-service system that rewards them for each procedure provided, not on the basis of outcomes for an episode of care.

However, a widely-cited review of the literature on cost-sharing by Harvard economist Katherine Swartz seriously questions the utility of charging consumers more for each service they use. While utilization of services is slowed, consumers tend to forgo appropriate care and inappropriate care in equal amounts.[5] This effect is acknowledged by the Medicare Payment Advisory Commission (MedPAC) in its June 2012 benefit redesign proposal.[6] Asking consumers to second-guess their doctor's recommendations is a flawed tool for ensuring that they are only getting the care they need.

The Swartz review also shows that cost-sharing's impact is more acute for vulnerable populations. A number of studies show that "low-income people in poor health are more likely to suffer adverse health outcomes, such as increased rates of emergency department (ED) use, hospitalizations, admission to nursing homes, and death, when increased cost-sharing causes them to reduce their use of health care…" For people with chronic illnesses, the literature finds that, "Increased cost-sharing disproportionately shifts financial risk to the very sick."

The National Association of Insurance Commissioners (NAIC) recently arrived at a similar understanding of the current evidence on cost sharing. The NAIC was charged by the Affordable Care Act (ACA) with devising an approach for nominal cost sharing in Medigap Plans C and F. NAIC, however, could not devise a workable approach for nominal cost-sharing based on existing research. In a letter to Health and Human Services (HHS) Secretary Sebelius, the Commissioners explained, "We were unable to find evidence in peer-reviewed studies or managed care practices that would be the basis of nominal cost sharing designed to encourage the use of appropriate physician's services." The Commissioners further explained that vulnerable beneficiaries could suffer poor health outcomes:

> None of the studies provided a basis for the design of nominal cost sharing that would encourage the use of appropriate physicians' services. Many of the studies caution that added cost sharing would result in delayed treatments that could increase Medicare program costs later (e.g., increased expenditures for emergency room visits and hospitalizations) and result in adverse health outcomes for vulnerable populations (i.e., elderly, chronically ill and low-income). [7]

Equity issues also arise from many of the proposals to impose first-dollar cost sharing requirements on all beneficiaries. For retirees that have supplemental health benefits provided to them by an employer, a multiemployer plan, or a Voluntary Employee Beneficiary Association (VEBA), the retirees have already sacrificed wages during their active working years on the promise that they would receive additional protection from health costs during retirement. If first-dollar coverage is prohibited outright, retirees in poor health would face unexpected, substantial out-of-pocket costs. If the limitation on first-dollar coverage was imposed through a surcharge on plans providing the coverage, many retirees could see reduced benefits in other areas. In addition, people with Medigap plans might have to change plans in response to the new costs. These beneficiaries would lose the protection of guaranteed renewal requirements, and face medical underwriting of their premiums.

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[5] Swartz, K. Cost-sharing: Effects on spending and outcomes. RWJ Foundation (December 2010) http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2011/rwjf402103/subassets/rwjf402103_1

[6] Medicare Payment Advisory Commission. Report to the Congress: Medicare and the health care delivery system. (June 2012) pp. 14 - 15. http://www.medpac.gov/chapters/Jun12_Ch01.pdf

[7] National Association of Insurance Commissioners. Letter to HHS Secretary Kathleen Sebelius, December 19, 2012. http://www.naic.org/documents/committees_b_sitf_medigap_ppaca_sg_121219_sebelius_letter_final.pdf.

Cost sharing is a blunt instrument that does more harm than good for the very sick, for the old, and for the poor. Medicare was designed, of course, to care for these very groups. Changing Medicare's benefit design to impose higher copays or coinsurance on beneficiaries may decrease federal expenditures on the program in the short run, but it represents a simple cost shift from the government to beneficiaries.

Medicare Beneficiaries are Lower-Income, have High Health Care Needs, and Already have More "Skin in the Game" than Most Consumers

Medicare beneficiaries can ill-afford to take on greater health care costs. According to AARP, "In 2010, half of all Medicare beneficiaries had annual income below $22,000, or below 200 percent of the federal poverty level."[8] Beneficiaries also tend to have a substantial need for medical services, as 46 percent of seniors covered by Medicare have three or more chronic conditions and 23 percent are in fair or poor health.[9] Because Medicare beneficiaries have modest incomes and high health care needs, changing the Medicare benefit structure to increase cost sharing will have a serious impact on the standard of living of millions with Medicare. Either they will pay the cost sharing directly, or their premiums will increase significantly for supplemental coverage.

In addition, seniors and people with disabilities already spend a greater share of their income on health care than other consumers. Medicare households have a lower average budget than the average household ($30,818 vs. $49,641 respectively) but devote a substantially larger share of their income to medical expenses than does the average household (14.7 percent vs. 4.9 percent respectively).[10] It is hard to argue that Medicare beneficiaries are insulated from the costs of their health care and need to shoulder more of the burden.

Improving the Capacity of the Medicare Program to Contain Costs

It is not necessary to impose increased cost sharing on Medicare beneficiaries in order to restrain spending in the program. For most of its history, Medicare has out-performed private insurance in containing health care costs. Between 1970 and 2009, Medicare spending per enrollee grew one percentage point less each year than comparable private health care premiums—or one third less over four decades. Medicare succeeds because of its low administrative costs and the use of bargaining power to hold down payment rates to providers.[11] Medicare is expected to out-perform private insurance over the next decade as well, with per capita spending growth of 3.1 percent compared to 4.9 percent for private insurance.[12]

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[8] AARP Public Policy Institute (March 2012) : http://www.aarp.org/content/dam/aarp/research/public_policy_institute/health/medicare-program-brief-overview-fs-AARP-ppi-health.pdf

[9] Kaiser Family Foundation. Key issues in understanding the economic and health security of current and future generations of seniors. (March 2012) http://www.kff.org/medicare/upload/8289.pdf

[10] Kaiser Family Foundation. Health care on a budget: The financial burden of health spending by Medicare households. (March 2012) http://www.kff.org/medicare/upload/8171-02.pdf

[11] Van de Water, P. Converting Medicare to premium support would likely lead to two-tier health care system. Center on Budget and Policy Priorities (September 2011), p. 1. http://www.cbpp.org/files/9-26-11health.pdf

[12] Kaiser Family Foundation. Medicare spending and financing. (November 2012) http://www.kff.org/medicare/upload/7305-07.pdf

Medicare is a market leader in the health care system, providing benchmarks for the pricing of services and innovating important delivery system reforms. Delivery system reforms in the Affordable Care Act have already enhanced its capacity to restrain costs. However, Medicare is currently unable to fully use its leverage as a bulk purchaser of services to bargain for lower health care prices. Allowing Medicare to negotiate drug prices for beneficiaries and to employ competitive bidding for health products could yield major savings – $230 billion over ten years from reduced drug prices[13] and $38 billion over the same span from lower costs for health products.[14] Similarly, moving from fee-for-service reimbursement to bundled payments and value-based purchasing are examples of approaches that help ensure that services are cost effective, lowering spending growth in the program. It is important that lawmakers provide Medicare with greater authority to negotiate prices for services, drugs, medical devices, and laboratory services on behalf of beneficiaries and taxpayers. Unleashing Medicare to pursue these savings would obviate the need to shift costs to beneficiaries.

Improving Medicare's Benefit Structure

The AFL-CIO sees benefit in improving Medicare's cost sharing structure so that beneficiaries can better predict the financial risks they face from future health care needs. There is important potential value in providing beneficiaries with an out-of-pocket cap, filling the prescription drug "donut hole" faster, and combining the outpatient and inpatient deductibles. Any rationalization of the cost sharing structure, however, will create winners and losers among the beneficiary population. We look forward to working with Congress to find an approach that is fair and ensures the health security of all Medicare beneficiaries.

Conclusion

Congress must not wrap benefit cuts in the guise of rationalizing Medicare's cost-sharing structure. Discussions that focus on "restructuring Medicare to preserve the program for future generations" should focus on improving Medicare's ability to bargain for cost-effective, high-quality services. To achieve this goal, Congress must grant Medicare greater authority to negotiate with providers, drug makers, medical device manufacturers, and equipment suppliers. Today's Medicare beneficiaries should fully benefit from the health security they earned in their working years while the program is put on a sound financial footing.

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[13] Center for Economic and Policy Research. Reducing waste with an efficient Medicare prescription drug benefit. (February 2013) http://www.cepr.net/documents/publications/medicare-drug-2012-12.pdf

[14] Center for American Progress. Senior protection plan. (November 2012) p. 5